EDMUND G. BROWN JR.
Attorney General of California
FRANK H. PACOE
Supervising Deputy Attorney General
JUSTIN R. SURBER
Deputy Attorney General
State Bar No. 226937
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 355-5437
Facsimile: (415) 703-5480
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MERCEDES APOSTOL TATEL** 1307 Tofts Drive San Jose, California 95131 **Registered Nurse License No. 470862** Respondent.	Case No. 2010-5 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1991, the Board of Registered Nursing issued Registered Nurse License Number 470862 to Mercedes Tatel (Respondent). On or about January 22, 2007, in a prior disciplinary action entitled In the Matter of the Accusation Against Mercedes Tatel, Board of Registered Nursing Case Number 2006-233, Respondent's license was revoked. However, the revocation was stayed and respondent was placed on probation for three years. Respondent's Registered Nurse License will expire on June 30, 2009, unless renewed.

///

///

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct...

. . ."

COSTS

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL ALLEGATIONS

8. On or about August 21, 2008, Respondent was terminated from her position as Clinical Nurse III in the Express Admission Unit ("EAU") at Santa Clara Valley Medical Center. On or about July 17, 2008, Dionnette Kelton, Nurse Manager of the EAU at Santa Clara Valley Medical Center, recommended that Respondent be terminated from her position at Santa Clara

Valley Medical Center. A hearing was scheduled for July 31, 2008, in which Respondent could have contested Ms. Kelton's allegations and recommendations. Respondent chose to forgo the hearing. Hearing officer Cheryl Dewey terminated Respondent in a decision effective August 21, 2008. A copy of the decision is attached as Exhibit A, and is incorporated by reference herein. Respondent's termination was based on the following factual findings:

a. Patient 1- Ms. E.M.

Ms. E.M. was admitted to the EAU on March 15, 2008, at 0810, with a diagnosis of arterial fibrillation with a rapid ventricular response (rapid heart rate) and chest pain. A physician ordered 5000 units of Heparin be administered subcutaneously every eight hours and 25 mg of Metoprolol be administered every six hours. Two doses of Heparin and two doses of Metoprolol were scheduled to be administered during Respondent's scheduled work shift. However, only one of the two doses of Heparin had been removed from the Pyxis (medication dispensing machine) during Respondent's shift. Neither of the two Metoprolol doses had been removed from the Pyxis during Respondent's shift.

Although only one dose of the Heparin had been removed from the Pyxis, Respondent documented on the patient's chart that she had administered two doses. Although no Metoprolol had been removed from the Pyxis, Respondents documented on the patient's chart that she had administered both doses. Respondent also failed to document the patient's vital signs every four hours as ordered by the physician. The Patient verified that she had not received these medications.

b. Patient #2- Ms. T.O.

Ms. T.O. was admitted to the EAU on March 31, 2008, at 0150, with a diagnosis of syncope. There was a physician order for 650 mg of Tylenol to be administered every four hours as needed for mild pain or fever. Respondent removed this medication from the Pyxis on March 31, 2008, at 0609, but failed to document in the patient's chart that the medication was given to the patient. Although this medication was only to be given on an as needed basis, Respondent administered this medication to patient despite Respondent's nurse's notes which state that the patient denied pain and had no complaints. The patient did not have a fever and did not indicate a

need for pain relief.

c. Patient #3- Ms. L.S.

Ms. L.S. was admitted to the EAU on March 28, 2008, with a diagnosis of chest pain. The patient had a physician's order for 100 mg for Hydrocortisone to be administered every six hours. Respondent documented in the patient's chart that she administered two doses of Hydrocortisone. However, only one dose was removed from the Pyxis. Respondent removed the medication from the Pyxis on March 29, 2008, at 0100, but documented on the patient's chart that the medication was administered on March 28, 2008, at 2400.

Ms. L.S. had a physician's order for 1-2 mg of Morphine to be administered every two hours as needed for pain. Respondent removed a dose of Morphine from the Pyxis on March 28, 2008, at 2243. However, Respondent documented on the patient's chart that it was administered at 2200. Although this medication was only to be administered for pain as needed, there was no mention of the patient's level of pain in Respondent's nurse's notes.

Ms. L.S. had an order for 500 mg of Azithromycin to be administered "now" and an additional 250 mg to be administered every 24 hours. Respondent documented that she administered both the 500 mg dose and the 250 mg dose of the medication to the patient at the same time (March 29, 2008, at 0030).

Ms. L.S. had an order for 0.4 mg of Nitroglycerin to be administered every five minutes as needed for chest pain. Respondent removed this medication from the Pyxis on March 28, 2008 at 2243, but did not document that the medication was administered to the patient on the patient's chart. There was no mention of chest pain in Respondent's nurse's notes.

d. Patient #4 -Ms. I.S.

Ms. I.S. was admitted to the EAU on March 29, 2008, with a diagnosis of COPD, arterial flutter, coronary artery disease, hypertension and diabetes. The patient had an order for 1 mg of Lorazepam (Ativan) to be given every eight hours as needed for anxiety. Respondent removed the drug from the Pyxis on April 1, 2008 at 0636, but documented on the patient's chart that Respondent administered it at 0600. Respondent failed to document the patient's response to this medication in Respondent's nurse's notes.

Ms. I.S. had an order for 1 mg of Morphine to be administered every two hours as needed for severe pain. Respondent removed 2 mg from the Pyxis on April 1, 2008, at 0136, but documented on the patient's chart that Respondent administered 1 mg at 0100. Respondent failed to document the waste of the extra 1 mg of medication. Although this medication was only to be administered for pain as needed, Respondent's nurse's notes both at 2400 and at 0400 stated that the patient's pain level was rated as "0".

e. Patient #5- Ms. C.O.

Ms. C.O. was admitted to EAU on March 15, 2008, at 2100, with a diagnosis of rule out acute coronary syndrome. A physician ordered 5000 units of Heparin be administered subcutaneously every eight hours. Respondent removed this medication from the Pyxis on March 16, 2008 at 0049, but did not administer it until 0500.

Ms. C.O. had a physician's order for 4 mg of Morphine to be administered now. Respondent removed the medication from the Pyxis on March 15, 2008, at 2216, but did not administer the dose until 2300.

Ms. C.O. also had a physician's order for 4 mg of Morphine to be administered every three hours as needed for severe pain. Respondent removed a dose from the Pyxis on March 16, 2008 at 0049, but did not administer it until 0200. The pain scale on the Patient Care Flow Sheet indicated that the patient had "0" pain at 2400. The next narrative note states the patient had pain rated 6/10 at 0030. Then the notes also state patient also rated the pain at "0" at 0100 and 0400.

Respondent administered another dose of Morphine at 0600. There was no mention of the patient's level of pain in Respondent's nurse's notes during this time frame, nor was there any documentation of the patient's response to this dose of pain medication.

f. Patient #6- Mr. E.O.

Mr. E.O. was admitted to the EAU on March 16, 2008, with a diagnosis of chronic pancreatitis and chronic alcohol abuse. According to Respondent's nurse's notes, the patient arrived in the EAU at 0330. There was a physician order for 4 mg of Morphine Sulfate to be administered every four hours as needed for severe pain. The Pyxis report showed that Respondent removed a 5 mg vial of Morphine on March 16, 2008, at 0341, but documented on

the patient's chart that Respondent administered the Morphine at 0100, two hours and thirty minutes before the patient arrived on the unit. Respondent also failed to document the waste of the 1 mg of morphine.

Respondent administered a second 4 mg dose of Morphine IV on March 16, 2008, at 0600, only two hours and twenty-five minutes after the last dose was given per the Pyxis report. There was no mention of the patient's level of pain in Respondent's nurse's notes during this time frame.

Mr. E.O. had a physician's order for 5000 units of Heparin to be administered subcutaneously every eight hours. Respondent removed this medication from the Pyxis on March 16, 2008, at 0604, but documented on the patient's chart that Respondent administered it at 0500.

Mr. E.O. had a physician's order for 100 mg of Thiamine to be administered daily with the first dose to be given immediately. Respondent removed this medication from the Pyxis on March 16, 2008, at 0606. Respondent documented on the patient's chart that Respondent administered the medication on March 15, 2008 at 2300, four hours and thirty minutes before the patient arrived at the unit.

g. Patient #7- Mr. R.D.

Mr. R.D. was admitted to the EAU on March 12, 2008, with a diagnosis of chest pain. A physician ordered 650 mg of Tylenol be given every eight hours as needed for fever or pain. Respondent removed the Tylenol from the Pyxis on March 13, 2008, at 0208, but failed to document that she had administered the medication on the patient's chart. Although this medication was only to be administered for pain as needed, Respondent's nurse's notes state that the patient had no complaints of pain and was without fever.

h. Patient #8- Mr. M.R.

Mr. M.R. was admitted to the EAU on March 3, 2008, with a diagnosis of end stage renal disease and coronary artery disease. A physician ordered 1 mg of Dilaudid be administered every four hours as need for pain. Respondent removed the medication from the Pyxis on March 4, 2008, at 2019, but documented on the medication record that Respondent gave Mr. M.R. the medication at 2200. Although this medication was only to be administered as need for pain, there was no mention of the patient's level of pain in Respondent's nurse's notes. Respondent's nurse's

notes at 2200 state that the patient was resting.

Mr. M.R. had a physician's order for 25 mg of Trazadone (Desyrel) to be administered as needed for insomnia. Respondent removed this medication from the Pyxis on March 4, 2008, at 2030, but failed to document the administration of the medication on the patient's chart. There was no mention of insomnia in Respondent's nurse's notes.

Mr. M.R. had a physician's order for 1-2 mg of Lorezapam (Ativan) to be administered every four hours as needed for anxiety or depression. Respondent administered 2 mg on March 4, 2008, at 2030, but there was no mention of the patient having anxiety or depression in Respondent's nurse's notes.

Mr. M.R. had a physician's order for 25 mg of Promethazine HCL (phenergan) to be administered every six hours as needed for nausea and vomiting. Respondent administered this medication to the patient on March 4, 2008, at 2030, but there was no mention of the patient having nausea or vomiting in Respondent's nurse's notes.

i. Patient #9- Ms. D.R

Ms. D.R. was admitted to the EAU on March 1, 2008, with a diagnosis of DKA (diabetic ketoacidosis). There was a physician order for 15 units of Glargine Insulin to be administered at bedtime. Respondent administered the medication on March 2, 2008, at 2100, but failed to have the medication checked, as required, with another nurse present. The administration of the medication was not noted on the diabetic record flow sheet as required by policy.

Ms. D.R. had a physician's order for 40 mg of KCL to be administered by IV. Respondent failed to indicate the time that the medication was administered to the patient.

j. Patient #10- Mr. K.M.

Mr. K.M. was admitted to the EAU on March 2, 2008, at 1930 with a diagnosis of chest pain and near syncope. A physician ordered 1 to 2 tablets of Vicodin to be administered every four hours as needed for pain. Respondent removed 2 tablets of Vicodin for the patient from the Pyxis on March 2, 2008, at 2138, but did not document the administration of the medication on the patient's chart. There was no documentation of the patient's level of pain in Respondent's nursing notes.

k. Patient #11- Mr. DZ.

Mr. D.Z. was admitted to EAU on February 28, 2008, at 1400, with a diagnosis of rule out acute coronary syndrome. Patient had a physician's order for 80 mg of Lasix to be administered every evening. Respondent did not remove the medication from the Pyxis but documented the medication as being administered to the patient on the patient's chart on February 28, 2008, at 2100.

Mr. E.O. had a physician's order for 50 mg of Hydralazine to be administered four times a day. Respondent did not remove the medication from the Pyxis but documented the medication as being administered to the patient on the patient's chart on February 28, 2008, at 2100.

Mr. E.O. had a physician's order for 2-5 mg of Morphine to be administered every four hours as needed for pain. Respondent removed 2 mg from the Pyxis machine on February 28, 2008, at 2113, but did not document that Respondent administered the medication on the patient's chart. There is no documentation of the patient's level of pain or the patient's response to this medication in Respondent's nurse's notes.

l. Patient #12- Mr. A.P.

Mr. A.P. was admitted to the EAU on February 18, 2008, with a diagnosis of chest pain and shortness of breath. A physician ordered 5000 units of Heparin be administered subcutaneously every eight hours. Respondent removed the medication from the Pyxis on February 19, 2008 at 0548 but documented on the patient's chart that Respondent administered the medication to the patient at 0500.

m. Patient #13- Mr. J.B.

Mr. J.B. was admitted to the EAU on February 13, 2008 with a diagnosis of syncope and R/O MI (rule out heart attack). On February 14, 2008, a physician ordered 2 mg of Morphine be administered every four hours as needed for pain. Respondent removed the medication from the Pyxis on February 14, 2008, at 2139, but failed to document that Respondent had administered this medication on the patient's chart. Respondent's nurse's notes state that Respondent gave the patient 2 mg of Morphine at 2100.

///

Mr. J.B. had a physician's order for 650 mg of Acetaminophen (Tylenol) to be administered every four hours as needed for mild pain or fever. Respondent removed this medication from the Pyxis on February 14, 2008, at 2140, but failed to document that Respondent had administered this medication on the patient's chart. Respondent's nurse's notes state that the patient was requesting pain medication. However, Respondent's notes did not reference the location or severity of the pain. The patient did not have a fever.

n. Patient #14- Ms J.F.

Ms. J.F. was admitted to the EAU on February 3, 2008, at 0030, with a diagnosis of nausea/vomiting. There was a physician's order for 25 mg of Phenergan (Promethazine Hydrochloride) to be administered every four hours as needed for nausea/vomiting. Respondent removed this medication from the Pyxis on February 3, 2008 at 0147, but did not document that Respondent administered the medication to the patient on the patient's chart. There was no mention of the patient having nausea or vomiting in Respondent's nurse's notes.

Ms. J.F. had a physician's order for 4-8 mg of Zofran (Ondansetron) to be administered every six hours as needed for nausea/vomiting. Respondent removed this medication from the Pyxis on February 3, 2008, at 0635, but did not document that Respondent administered this medication to the patient on the patient's chart. There was no mention of the patient having nausea or vomiting in Respondent's nurse's notes.

o. Patient #15- Mr. H.J

Mr. H.J. was admitted to the EAU on January 22, 2008, at 0115, with a diagnosis of hypertensive emergency. A physician ordered 10 mg of Hydralazine be administered every four hours as needed for systolic blood pressure greater than 180. Respondent removed the medication from the Pyxis on January 22, 2008, at 0321, but documented on the patient's chart that it was given at 0100. The blood pressure documented at 0200 was 195/118.

p. Patient #16- Ms. M.R.

Ms. M.R. was admitted to EAU on January 16, 2008, at 0010, with a diagnosis of hydrocephalus. A physician ordered 1 mg of Morphine be administered every four hours as needed for severe pain. Respondent documented that she administered the medication to the

patient on January 16, 2008, at 0630, but failed to document the level of the patient's pain in Respondent's nurse's notes.

q. Patient #17- Mr. M.K.

Mr. M.K. was admitted to EAU on January 15, 2008, with a diagnosis of intra hepatic obstruction. There was a physician's order for 1-2 mg of Morphine to be administered every six hours as needed for severe pain. Respondent removed 2 mg from the Pyxis on January 16, 2008, at 0044, but documented that Respondent administered 1 mg at 0100. Respondent failed to document the waste of the extra 1 mg. Respondent removed a second 2 mg dose of Morphine from the Pyxis on January 16, 2008, at 0325, but documented on the patient's chart that Respondent administered the 2 mg dose at 0600. Respondent's nurse's notes at 0100 and 0500 state that the patient had generalized pain, but there was no mention of the severity of the pain.

Mr. M.K. had a physician's order for 650 mg of Tylenol to be administered every four hours as needed for mild pain or fever. Respondent removed this medication from the Pyxis on January 16, 2008, at 0400, but failed to document that Respondent had administered the medication to the patient on the patient's chart. At 0400, the pain rated on the Patient Care Flow Sheet was "0" and the patient had no fever.

r. Patient #18- Mr. L.L.

Mr. L.L. was admitted to the EAU on January 7, 2008. There was a physician's order for 12.5-25 mg of Promethezine (Phenergan) to be administered every four hours as needed for nausea / vomiting. Respondent removed 4 mg of Ondansetron (Zofran) from the Pyxis on January 8, 2008, at 0349. Ondansetron (Zofran) was never ordered for this patient. Although Respondent removed the Zofran for this patient, Respondent did not document that Respondent administered Zofran on the patient's chart. Instead, Respondent documented that she administered 12.5 mg of Phenergan on January 8, 2008, at 0345. There is no mention of the patient having nausea or vomiting in Respondent's nurse's notes.

Mr. L.L. had a physician's order for 650 mg of Tylenol to be administered as needed for mild pain. On January 8, 2008, at 0350, Respondent removed Tylenol (300 mg) with Codeine (30 mg) Elixir from the Pyxis. There was no physician order for this medication.

s. Patient #19- Ms. C.F.

Ms. C.F. was admitted to the EAU on January 6, 2008, with a diagnosis of pneumonia. A physician ordered 650 mg of Tylenol be administered every four hours as needed for mild pain. Respondent removed the Tylenol from the Pyxis on January 6, 2008, at 2333, but failed to document that it was administered on the patient's chart.

t. Patient #20- Mr. M.F.

Mr. M.F. was admitted to the EAU on January 4, 2008, with a diagnosis of alcohol withdrawal. The patient arrived on the unit at 0200 and had a physician's order for 10 mg of Valium to be administered every hour until the patient was calm, but not sedated. Respondent removed 10 mg from the Pyxis on January 4, 2008, at 0259, but documented on the patient's chart that Respondent administered the medication on January 4, 2008, at 2400, two hours prior to the patient's arrival to the unit. There is no mention of distress or withdrawal symptoms in Respondent's nurse's notes.

u. Patient #21- Ms. E.R

Ms. E.R was admitted to the EAU on January 2, 2008, with a diagnosis of new onset diabetes. A physician ordered 500 mg of Metformin be administered twice a day. Respondent removed the medication from the Pyxis on January 3, 2008, at 0109, but did not document that it was administered on the patient's chart. Respondent instead documented that Respondent gave the medication in Respondent's nurse's notes. Respondent transferred the patient to another unit at 0445. It was the receiving nurse that indicated on the patient's chart that the medication was given in the EAU.

On January 2, 2008, at 2250, a physician ordered Ms. E.R.'s glucose levels be obtained every four hours. Respondent failed to document any of the blood glucose levels on the diabetic record during Respondent's shift for this patient.

v. Patient #22- Mr. V.B.

Mr. V.B. was admitted to the EAU on January 1, 2008, with a diagnosis of pneumonia. A physician ordered 5000 units of Heparin be administered subcutaneously every eight hours. Respondent removed the medication from the Pyxis on January 3, 2008, at 0622, but documented

on the patient's chart that it was administered at 0500. A physician also ordered 1 to 2 tablets of Percocet be administered every four hours as needed for pain. Respondent administered two doses. Respondent removed the second dose from the Pyxis on January 3, 2008, at 0620, but documented on the patient's chart that Respondent administered the medication at 0700. Respondent failed to document the severity of the pain in Respondent's nurse's notes.

CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

9. Respondent is subject to disciplinary action under section 2761(a) of the code in that Respondent was involved in unprofessional conduct. The circumstances are described in paragraph 8 above.

DISCIPLINE CONSIDERATIONS

10. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about January 22, 2007, in a prior disciplinary action entitled In the Matter of the Accusation Against Mercedes Tatel, Board of Registered Nursing Case Number 2006-233, Respondent's license was revoked. However, the revocation was stayed and respondent was placed on probation for three years. Respondent's license was disciplined for conduct involving in gross negligence, failure to perform disease prevention and failure to follow infection control guidelines. That decision is now final and is incorporated by reference as if fully set forth. Respondent is currently on probation.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 470862, issued to Mercedes Tatel.

2. Ordering Mercedes Tatel to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

///

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/3/09

for RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2009404006
40344434.doc

EXHIBIT A

Dedicated to the Health
of the Whole Community

SANTA CLARA VALLEY MEDICAL CENTER

Nursing Administration
Annex Building
751 S. Bascom Ave.
San Jose, CA 95128
Tel (408) 885-6700
Fax (408) 885-6720

August 12, 2008

7000-1670-0006-2726-8080
Sent via Certified and US Mail

Ms. Mercedes Tatel
1307 Tofts Drive
San Jose, CA 95131

SUBJECT: NOTICE Final Disciplinary Action – HEARING OFFICER'S DECISION

Dear Ms. Tatel:

In her letter dated July 17, 2008, Dionette Kelton, Nurse Manager, Express Admission Unit, recommended that you be terminated from your position as a Clinical Nurse III in the Express Admission Unit (EAU) effective **August 21, 2008.**

This action is based on, but not limited to, the following charges:

A. Violation of Merit System Rules, Article 11:

1. Section A25-301 (a) (1) "Violation of the county charter, merit system rules and regulations, and written published departmental rules and policies which do not conflict with this article."

2. Section A25-301 (a) (2) "Inefficiency, incompetency, or negligence in the performance of duties, including failure to perform assigned task or failure to discharge duties in a prompt, competent and responsible manner." **(Attachment 1)**

B. Violation of SCVMC Nursing Standards of Governance:

1. QI-31 (I) (A) Nursing care requires "direct and indirect patient care services that ensure the safety, comfort, personal hygiene and protection of patients and the performance of disease prevention and restorative measures." (California Nursing Practice Act, 2001, Chapter 6, section 2725)

2. QI-31 (I) (B) Nursing care requires "direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by the physician." (California Nursing Practice Act, 2001, Chapter 6, section 2725)

3. QI-31 (I) (D) Nursing care requires "observation of signs and symptoms of illness, reactions to treatment, general behavior or general physical condition and

determination of whether the signs, symptoms, reactions, behavior or general appearance exhibit abnormal characteristics. Implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures or the initiation of emergency procedures. " (California Nursing Practice Act, 2001, Chapter 6, section 2725)

4. QI-31 (II) "The American Nurses Association (ANA) Standards (2004) "describe a minimum level of nursing performance common to the profession. Clinical nursing standards ensure compliance with Standards of Practice, which prescribe a competent level of nursing practice, and Standard of Professional Performance, which articulate the roles and behaviors expected of nursing professionals."

5. QI-31 (III) (A) quoted in part: ANA Standard 1: Assessment. "The registered nurse collects comprehensive data pertinent to the patient's health or the situation." The RN "collects data in a systematic and ongoing process." The RN "prioritizes data collection activities based on the patient's immediate condition, or anticipated needs of the patient or situation." The RN "synthesizes available data, information, and knowledge relevant to the situation to identify patterns and variances." The RN "documents relevant data in a retrievable format."

6. QI-31 (III) (B) ANA Standard 2: Diagnosis. "The registered nurse analyzes the assessment data to determine the diagnoses or issues."

7. QI-31 (III) (E) quoted in part: ANA Standard 5: Implementation. "The registered nurse implements the identified plan." The RN "implements the plan in a safe and timely manner." The RN "documents implementation and any modifications, including changes or omission of the identified plan," The RN "collaborates with nursing colleagues and others to implement the plan."

8. QI-31 (III) (F) ANA Standard 5A: Coordination of Care. "The registered nurse coordinates care delivery." The RN "coordinated implementation of the plan" and "documents the coordination of the care."

9. QI-31 (III) (H) ANA Standard 6: Evaluation "The registered nurse evaluates progress toward attainment of outcomes." The RN "conducts a systematic, ongoing, and criterion-based evaluation of the outcomes in relation to the structures and processes prescribed by the plan and the indicated timeline." The RN "evaluates the effectiveness of the planned strategies in relation to patient responses and the attainment of the expected outcomes." The RN "documents the result of the evaluation." The RN "uses ongoing assessment data to revise the diagnoses, outcomes, the plan, and the implementation as needed."

10. QI-31 (IV) (A) quoted in part: ANA Standard 7: Quality of Practice. "The registered nurse systematically enhances the quality of effectiveness of nursing practice." The

RN "demonstrates the application of the nursing process in a responsible, accountable, and ethical manner."

11. QI-31 (IV) (H) quoted in part: ANA Standard 14: Resource Utilization "The registered nurse considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing services." The RN "evaluates factors such as safety, effectiveness, availability, cost and benefits, efficiencies, and impact on practice when choosing practice options that would result in the same expected outcome." The RN "assigns or delegates tasks based on the needs and condition of the patient, potential for harm, stability of the patient's condition, complexity of the tasks and predictability of the outcome." **(Attachment 2)**

C. Violation of SCVMC Nursing Standards of Care:

1. DOC-4 (I) (A) "Documentation in the nurse's notes of the patient medical record shall be readable, concise, and reflect the patient's status, needs, problems, capabilities, and limitations. Nursing intervention, evaluation of patient response and reassessment shall be included in the documentation."

2. DOC-4 (I) (B) " Documentation in other parts of the patient medical record, e.g., patient care plan, medication administration record, Patient Care Record, etc. shall also be clear, concise, accurate, and legible."

3. DOC-4 (III) (D) "Document everything done as soon as possible. Note the patient's responses to treatments, medications and instructions."

4. DOC-4 (III) (P) "RN must review any documentation by the HSA (hospital service assistant)" **(Attachment 3)**.

5. MED-1 (I) (A) "At Santa Clara Valley Medical Center, medications and drugs shall be administered only by Registered Nurses, Licensed Vocational Nurses, Licensed Psychiatric Technicians, Nurse Practitioners, Respiratory Therapist, and Physician's Assistants authorized to administer medications and only upon the order of a physician or licensed personnel authorized to prescribe."

6. MED-1 (I) (E) quoted in part "Medications shall be kept in lockable, secured areas inaccessible to unauthorized persons."

7. MED-1 (III) (A) (1) (c) "Each licensed nursing staff member is responsible for his or her own safe practice in handling and administering medications. Such responsibility includes, but is not limited to assuring that there is a valid order for the medication."

8. MED-1 (III) (A) (2) "Each licensed nurse is responsible for assuring that medications have not expired and are given according the following principles: the right patient, the right time; the right route; the right medication; the right dose."

9. MED-1 (III) (A) (9) (a) (ii) quoted in part: "The following drugs must be checked by two licensed nurses and documented on the MAR (medication administration record) or other appropriate location: Insulin – document double checking process on Diabetic Record."

10. MED-1 (III) (A) (10) quoted in part: "Any wastage for any controlled substances must be witnessed and co-signed by another licensed staff member on the Controlled Drug Record or Pyxis."

11. MED-1 (III) (A) (12) quoted in part: "Any drug administered must be documented immediately after administration by the nursing staff or Physician who administered the drug on the unit medication administration record."

12. MED-1 (III) (A) (14) "Indications for PRN (as needed) medications and the patient's response to drug therapy are observed and documented in the Medical Record."

13. MED-1 (III) (A) (15) (a) quoted in part "All scheduled subcutaneous (SQ) insulin doses are documented on the MAR and diabetic record."

14. MED-1 (V) (A) (1) Administration and Charting – "Locate MAR medications may be given 30 minutes before or 30 minutes after the scheduled medication administration time."

15. MED-1 (V) (A) (2) Administration and Charting –"Validate patient's identification using 2 patient identifiers and confirm the five (5) rights of medication administration."

16. MED-1 (V) (A) (5) Administration and Charting – "Chart immediately after confirmed administration."

17. MED-1 (V) (A) (6) Administration and Charting – "If a medication is not given as ordered indicate by writing the time that the medication was to be given and circle the time, specifying the reason(s) by using corresponding omission code, found at the bottom of the MAR" **(Attachment 4).**

18. MED-12 (V) (B) Wasting a Medication – Key Points "Two licensed personnel will be required to return a controlled substance and document a "witnessed return" **(Attachment 5).**

D. Violation of SCVMC Administrative Policies and Procedures Manual - VMC #301.43 Pain Management (quoted in part): "For every patient, pain will be assessed and treated promptly, effectively, and for as long as pain persists, by utilizing all available interventions/resources necessary to achieve acceptable pain management. Pain is what the patient says it is; patient's self-report using a pain rating scale (e.g., 0-10). All patients have a right to have the issues of pain actively addressed. Pain management is an ongoing process requiring routine reassessment to evaluate the efficacy of interventions.

Upon admission, the MD/RN will assess each patient for pain using the Wong Baker 0 to 10 pain intensity scale. The licensed nurse will reassess each patient for pain following interventions to relieve pain" **(Attachment 6).**

The facts upon which the above charges are based:

You were hired as a Clinical Nurse III in the Express Admission Unit (EAU) on November 20, 2004. You are currently assigned to work 7:00 pm to 7:00 am. The EAU is an extension of the emergency room. It is considered an interim location for most of the adult medical admissions. In this unit, the medical work up, urgent diagnostic testing and medication administration continues while the physician determines if a patient's condition is going to require admission to an inpatient unit. As a Clinical Nurse III, you are expected to identify and implement nursing interventions, which have less predictable outcomes and evaluate the results of these interventions.

When Ms. Kelton hired you, she was unaware that you were being investigated by the Board of Registered Nurses. The Board of Registered Nurses placed you on probation for a period of three years for an incident that occurred prior to your employment at Santa Clara Valley Medical Center (SCVMC). The causes of this disciplinary action included gross negligence (exposure to infectious disease); failure to perform disease prevention and failure to follow infection control guidelines.

In early February of 2007, She became aware that you had been placed on probation and that there was a disciplinary action against your license. On February 7, 2007, she agreed to maintain the maximum supervision required for you to continue employment, which consisted of the following:

- You could not supervise other registered nurses including the assignment as a charge nurse or preceptor;
- You could not provide nursing instruction for continuing education;
- You could not float to other areas;
- You could not work any overtime;
- You were to be evaluated monthly for six months and thereafter quarterly;
- You were not to provide nursing services that were significantly different than what was within your current job description;
- You were to report to the Board of Registered Nurses any problems or reportable incidents within 72 hours;
- All of your supervisors had to be aware of the requirements of your probation with the Board of Registered Nurses and participate in the evaluation of your practice **(Attachment 7).**

On March 18, 2008, Ms. Hala, RN, informed the Assistant Nurse Manager, Ms. Paeste, that you had not administered the scheduled medications (Heparin and Metoprolol) to your patient, Ms. E.M. (Patient #1). This patient was admitted from the emergency department on March 15, 2008 at 0810 with a diagnosis of arterial fibrillation with a rapid ventricular response (rapid heart rate)

and chest pain. The physician ordered Heparin 5000 units subcutaneous to be given every eight hours **(Attachment 8)** and Metoprolol 25 mg to be given orally every six hours **(Attachment 9)**.

Two doses of Heparin (2100 and 0500) and two doses of Metoprolol (2400 and 0600) were to be given during your scheduled work shift. Ms. Hala stated that when she went to retrieve medications for this patient from the Pyxis (medication dispensing machine) she noticed that only one of the two doses of Heparin had been removed and neither of the two Metoprolol doses had been removed **(Attachment 10)**. Ms. Hala also told Ms. Paeste that the patient verified that she had not received these medications during the night.

Although only one dose of the Heparin had been removed from the Pyxis, you documented on the patient's chart that you had administered two doses. And, although no Metoprolol had been removed from the Pyxis, you documented on the patient's chart that you had administered both doses **(Attachment 11)**. You also failed to document the patient's vital signs every four hours as ordered by the physician **(Attachment 12)**.

Because of the seriousness of the allegations, Ms. Kelton reviewed the other patients assigned to you on that work shift, which revealed the following:

Patient #5 Ms. C.O.
Ms. C.O. was admitted to EAU on March 15, 2008 at 2100 with a diagnosis of rule out acute coronary syndrome. The physician ordered Heparin 5000 units subcutaneous every eight hours (**Attachment 13**). You removed this medication from the Pyxis on March 16, 2008 at 0049 **(Attachment 14)**, but did not administer it until 0500 **(Attachment 15)**.

On March 15, 2008, Ms. C.O. had an order to administer Morphine 4 mg IV now **(Attachment 16)**. You removed the medication from the Pyxis on March 15, 2008 at 2216 **(Attachment 14)**, but did not administer the dose until 2300 **(Attachment 17)**. There was no mention of the patient's level of pain in your nurse's notes, nor was there documentation of the patient's response to the pain medication **(Attachment 18)**.

Ms. C.O. had a physician's order for Morphine 4 mg IV every three hours as needed for severe pain **(Attachment 19)**. You removed the dose from the Pyxis on March 16, 2008 at 0049 **(Attachment 14)**, but did not administer it until 0200 **(Attachment 20)**. The pain scale on the Patient Care Flow Sheet indicated that the patient had "0" pain at 2400 **(Attachment 21)**. The next narrative note states the patient had pain rated 6/10 at 0030 **(Attachment 22)**. Then at 0100 and 0400, pain had been rated as "0" **(Attachment 21)**.

You administered another dose of Morphine 4 mg IV at 0600 **(Attachment 20)**. There was no mention of the patient's level of pain in your nurse's notes during this time frame, nor was there any documentation of the patient's response to this dose of pain medication **(Attachments 21 and 22)**.

Patient #6 Mr. E.O.
Mr. E.O. was admitted to the EAU on March 16, 2008 with a diagnosis of chronic pancreatitis and chronic alcohol abuse. According to your nurse's notes, the patient arrived in the EAU at

0330 **(Attachment 23)**. There was a physician order for Morphine Sulfate 4 mg IV every four hours as needed for severe pain **(Attachment 24)**. The Pyxis report showed that you removed a 5 mg vial of Morphine on March 16, 2008 at 0341 **(Attachment 25)**, but documented on the patient's chart that you administered 4 mg at 0100 **(Attachment 26)**, which was two hours and thirty minutes before the patient arrived on the unit. You also failed to document the waste of the 1 mg of morphine (the amount not administered to the patient) **(Attachment 25)**.

You administered a second dose of Morphine 4 mg IV on March 16, 2008 at 0600 **(Attachment 26)**, which was only two hours and twenty-five minutes after the last dose was given per the Pyxis report **(Attachment 25)**. There was no mention of the patient's level of pain in your nurse's notes during this time frame **(Attachment 27)**.

The patient had a physician order for Heparin 5000 units subcutaneous every eight hours **(Attachment 28)**. You removed this medication from the Pyxis on March 16, 2008 at 0604 **(Attachment 25)**, but documented on the patient's chart that you administered it at 0500 **(Attachment 26)**.

The physician ordered Thiamine 100 mg orally daily with the first dose to be given immediately **(Attachment 29)**. You removed this medication from the Pyxis on March 16, 2008 at 0606 **(Attachment 25)**, but documented on the patient's chart that you administered it on March 15, 2008 at 2300 **(Attachment 26)**, which was four hours and thirty minutes prior to the patient arriving to the unit.

Based on the seriousness of these findings and the concern for patient safety, you were placed on Administrative Leave effective April 1, 2008. Further review of your practice revealed the following:

Patient #2 Ms. T.O.
Ms. T.O. was admitted to the EAU on March 31, 2008 at 0150 with a diagnosis of syncope. There was a physician order for Tylenol 650 mg orally every four hours as needed for mild pain or fever **(Attachment 30)**. You removed this medication from the Pyxis on March 31, 2008 at 0609 **(Attachment 31)**, but failed to document in the patient's chart that the medication was given to the patient **(Attachment 32)**.

Although this medication was only to be given on an as needed basis, and your nurse's notes state that the patient denied pain and had no complaints, you still administered this medication to the patient **(Attachment 33)**. The patient did not have a fever and did not indicate a need for pain relief **(Attachment 34)**.

Patient #3 Ms. L.S.
Ms. L.S. was admitted to the EAU on March 28, 2008 with a diagnosis of chest pain. The patient had a physician order for Hydrocortisone 100 mg IV every six hours **(Attachment 35)**.

You removed the medication from the Pyxis on March 29, 2008 at 0100 **(Attachment 36)**, but documented on the patient's chart that you administered it on March 28, 2800 at 2400

(Attachment 37). You documented in the patient's chart that you administered two doses of Hydrocortisone 100 mg IV again, however you only removed one dose from the Pyxis.

Ms. L.S. had an order for Morphine 1 mg to 2 mg IV every two hours as needed for pain **(Attachment 38)**. You removed a dose from the Pyxis on March 28, 2008 at 2243 **(Attachment 36),** but documented on the patient's chart that it was administered at 2200 **(Attachment 39).** Although this medication was only to be administered for pain as needed, there was no mention of the patient's level of pain in your nurse's notes **(Attachment 40).**

Ms. L.S. had an order for Azithromycin 500 mg IV now and 250 mg every 24 hours **(Attachment 41)**. You documented that you administered both the 500 mg and the 250 mg of the medication to the patient on March 29, 2008 at 0030 - both doses at the same time **(Attachments 37 and 42).**

Ms. L.S. had an order for Nitroglycerin 0.4 mg every five minutes as needed for chest pain **(Attachment 38)**. You removed this medication from the Pyxis on March 28, 2008 at 2243 **(Attachment 36),** but did not document that the medication was administered to the patient on the patient's chart **(Attachment 39).** There was no mention of chest pain in your nurse's notes **(Attachment 40).**

Patient #4 Ms. I.S.

Ms. I.S. was admitted to the EAU on March 29, 2008 with a diagnosis of COPD, arterial flutter, coronary artery disease, hypertension and diabetes. The patient had an order for Lorazepam (Ativan) 1 mg to be given orally every eight hours as needed for anxiety **(Attachment 43).** You removed the drug from the Pyxis on April 1, 2008 at 0636 **(Attachment 44),** but documented on the patient's chart that you administered it at 0600 **(Attachment 45).** You failed to document the patient's response to this medication in your nurse's notes **(Attachment 47).**

Ms. I.S. had an order for Morphine 1 mg IV every two hours as needed for severe pain **(Attachment 43).** You removed 2 mg from the Pyxis on April 1, 2008 at 0136 **(Attachment 44),** but you documented on the patient's chart that you administered 1 mg at 0100 **(Attachment 45).** You failed to document the waste of the extra 1 mg of medication that was not administered to the patient **(Attachment 44).**

Although this medication was only to be administered for pain as needed, your nurse's notes both at 2400 and at 0400 stated that the patient's pain level was rated as "0" **(Attachments 46 and 47).**

Patient #7 Mr. R.D.

Mr. R.D. was admitted to the EAU on March 12, 2008 with a diagnosis of chest pain. The physician ordered Tylenol 650 mg to be given orally every eight hours as needed for fever or pain. You removed the Tylenol from the Pyxis on March 13, 2008 at 0208 **(Attachment 48).** but failed to document that you had administered the medication on the patient's chart **(Attachment 49).**

Although this medication was only to be administered for pain as needed, your nurse's notes state that the patient had no complaints of pain **(Attachments 50 and 51)** and was without fever **(Attachment 52)**.

Patient #8 Mr. M.R.
Mr. M.R. was admitted to the EAU on March 3, 2008 with a diagnosis of end stage renal disease and coronary artery disease. The physician ordered Dilaudid 1 mg IV every four hours as needed for pain **(Attachment 53)**. You removed the medication from the Pyxis on March 4, 2008 at 2019 **(Attachment 54)**, but documented on the medication record that you gave Mr. M.R. the medication at 2200 **(Attachment 55)**.

Although this medication was only to be administered for pain as needed, there was no mention of the patient's level of pain in your nurse's notes **(Attachment 56)**. Your nurse's note at 2200 state that the patient was resting **(Attachment 57)**.

Mr. M.R. had a physician order for Trazadone (Desyrel) 25 mg orally as needed for insomnia **(Attachment 58)**. You removed this medication from the Pyxis on March 4, 2008 at 2030 **(Attachment 54)**, but failed to document the administration of the medication on the patient's chart **(Attachment 59)**. There was no mention of insomnia in your nurse's notes **(Attachment 57)**.

The physician ordered Lorezapam (Ativan) 1 mg to 2 mg IV / orally every four hours as needed for anxiety or depression **(Attachment 58)**. You administered 2 mg IV on March 4, 2008 at 2030 **(Attachment 59)**, but there was no mention of the patient having anxiety or depression in your nurse's notes **(Attachment 57)**.

The physician ordered Promethazine HCL (phenergan) 25 mg orally / IV every six hours as needed for nausea / vomiting **(Attachment 58)**. You administered this medication to the patient on March 4, 2008 at 2030 **(Attachment 59)**, but there was no mention of the patient having nausea or vomiting in your nurse's notes **(Attachment 57)**.

Patient #9 Ms. D.R
Ms. D.R. admitted to the EAU on March 1, 2008 with a diagnosis of DKA (diabetic ketoacidosis). There was a physician order for Glargine Insulin 15 units subcutaneous to be administered at bedtime **(Attachment 60)**. You administered the medication on March 2, 2008 at 2100, but failed to have the medication checked, as required with another nurse present **(Attachment 61)**. The administration of the medication was not noted on the diabetic record flow sheet **(Attachment 62)** as required by policy.

There was also a physician order for KCL 40 meq to be given IV. You failed to indicate the time that the medication was administered to the patient **(Attachment 63)**.

Patient #10 Mr. K.M.
Mr. K.M. was admitted to the EAU on March 2, 2008 at 1930 with a diagnosis of chest pain and near syncope. The physician ordered Vicodin 1 to 2 tablets orally every four hours as needed for pain **(Attachment 64)**. You removed 2 tablets of Vicodin for the patient from the Pyxis on

March 2, 2008 at 2138 **(Attachment 65)**, but did not document the administration of the medication on the patient's chart **(Attachment 66)**. Neither was there documentation of the patient's level of pain in your nurse's notes **(Attachment 67)**.

Patient #11 Mr. D.Z.
Mr. D.Z. was admitted to EAU on February 28, 2008 at 1400 with a diagnosis of Rule Out Acute Coronary Syndrome. The physician ordered Lasix 80 mg orally every evening **(Attachment 68)**. You did not remove the medication from the Pyxis **(Attachment 69)**, but you documented the medication as being administered to the patient on the patient's chart on February 28, 2008 at 2100 **(Attachment 70)**.

There was a physician order for Hydralazine 50 mg orally four times a day **(Attachment 68)**. You did not remove the medication from the Pyxis **(Attachment 69)**, but you documented the medication as being administered to the patient on the patient's chart on February 28, 2008 at 2100 **(Attachment 71)**.

There was a physician order for Morphine 2 mg to 5 mg to be given IV every four hours as needed for pain **(Attachment 68)**. You removed 2 mg from the Pyxis machine on February 28, 2008 at 2113 **(Attachment 69)**, but did not document that you administered the medication on the patient's chart **(Attachment 72)**. There is no documentation of the patient's level of pain or the patient's response to this medication in your nurse's notes **(Attachment 73)**.

Patient #12 Mr. A.P.
Mr. A.P. was admitted to the EAU on February 18, 2008 with a diagnosis of chest pain and shortness of breath. The physician ordered Heparin 5000 units subcutaneous to be administered every eight hours **(Attachment 74)**. You removed the medication from the Pyxis on February 19, 2008 at 0548 **(Attachment 75)**, but documented on the patient's chart that you administered the medication to the patient at 0500 **(Attachment 76)**.

Patient #13 Mr. J.B.
Mr. J.B. was admitted to the EAU on February 13, 2008 with a diagnosis of syncope and R/O MI (rule out heart attack). On February 14, 2008 the physician ordered Morphine 2 mg IV every four hours as needed for pain **(Attachment 77)**. You removed the medication from the Pyxis on February 14, 2008 at 2139 **(Attachment 78)**, but failed to document that you had administered this medication on the patient's chart **(Attachment 79)**. You charted in your nurse's notes that you gave the patient 2 mg of Morphine at 2100 **(Attachment 80)**.

Additionally, the physician ordered Acetaminophen (Tylenol) 650 mg orally every four hours as needed for mild pain or fever **(Attachment 81)**. You removed this medication from the Pyxis on February 14, 2008 at 2140 **(Attachment 78)**, but failed to document that you had administered this medication on the patient's chart **(Attachment 82)**. Your nurse's notes state that the patient was requesting pain medication, but your notes did not reference the location or severity of the pain **(Attachments 80 and 83)**. The patient did not have a fever **(Attachment 84)**.

Patient #14 Ms J.F

Ms. J.F. was admitted to the EAU on February 3, 2008 at 0030 with a diagnosis of nausea/vomiting. There was a physician order for Phenergan (Promethazine Hydrochloride) 25 mg IV every four hours as needed for nausea / vomiting **(Attachment 85)**. You removed this medication from the Pyxis on February 3, 2008 at 0147 **(Attachment 86)**, but did not document that you administered the medication to the patient on the patient's chart **(Attachment 87)**. There was no mention of the patient having nausea or vomiting in your nurse's notes **(Attachment 88)**.

There was a physician order for Zofran (Ondansetron) 4 mg to 8 mg IV to be given every six hours as needed for nausea / vomiting **(Attachment 89)**. You removed this medication from the Pyxis on February 3, 2008 at 0635 **(Attachment 86)**, but did not document that you administered this medication to the patient on the patient's chart **(Attachment 87)**. There was no mention of the patient having nausea or vomiting in your nurse's notes **(Attachment 88)**.

Patient #15 Mr. H.J

Mr. H.J. was admitted to the EAU on January 22, 2008 at 0115 with a diagnosis of hypertensive emergency. The physician ordered Hydralazine 10 mg IV every four hours as needed for systolic blood pressure greater than 180 **(Attachment 90)**. You removed the medication from the Pyxis on January 22, 2008 at 0321 **(Attachment 91)**, but documented on the patient's chart that it was given at 0100 **(Attachment 92)**. The blood pressure documented at 0200 was 195/118 **(Attachment 93)**.

Patient #16 Ms. M.R.

Ms. M.R. was admitted to EAU on January 16, 2008 at 0010 with a diagnosis of hydrocephalus. The physician ordered Morphine 1 mg IV every four hours as needed for severe pain **(Attachment 94)**. You documented that you administered the medication to the patient on January 16, 2008 at 0630 but failed to document the level of the patient's pain in your nurse's notes **(Attachment 95)**.

Patient #17 Mr. M.K.

Mr. M.K. was admitted to EAU on January 15, 2008 with a diagnosis of intra hepatic obstruction. There was a physician order for Morphine 1 mg to 2 mg IV every six hours as needed for severe pain **(Attachment 97)**. You removed 2 mg from the Pyxis on January 16, 2008 at 0044 **(Attachment 98)**, but documented that you administered 1 mg at 0100 **(Attachment 99)**. You failed to document the waste of the extra 1 mg **(Attachment 98)**. You removed a second dose of Morphine 2 mg from the Pyxis on January 16, 2008 at 0325 **(Attachment 98)**, but documented on the patient's chart that you administered the patient 2 mg at 0600 **(Attachment 99)**. Your nurse's notes at 0100 and 0500 state that the patient had generalized pain, but there was no mention of the severity of the pain **(Attachments 100 and 101)**.

Mr. M.K. had a physician order for Tylenol 650 mg orally every four hours as needed for mild pain or fever **(Attachment 97)**. You removed this medication from the Pyxis on January 16, 2008 at 0400 **(Attachment 98)**, but failed to document that you had administered the medication to the patient on the patient's chart **(Attachment 102)**. At 0400, the pain rated on the Patient Care Flow Sheet was "0" **(Attachment 100)** and the patient had no fever **(Attachment 103)**.

Patient #18 Mr. L.L.
Mr. L.L. was admitted to the EAU on January 7, 2008. There was a physician order for Promethezine (Phenergan) 12.5 mg to 25 mg IV every four hours as needed for nausea / vomiting **(Attachment 104)**.

You removed Ondansetron (Zofran) 4 mg IV from the Pyxis on January 8, 2008 at 0349 **(Attachment 105)**. This medication was never ordered for this patient.

Although you removed the Zofran for this patient, you did not document that you administered Zofran on the patient's chart. Instead, you documented that you administered the patient Phenergan 12.5 mg IV on January 8, 2008 at 0345 **(Attachment 106)**. There is no mention of the patient having nausea or vomiting in your nurse's notes **(Attachment 107)**.

Mr. L.L. also had an order for Tylenol 650 mg as needed for mild pain **(Attachment 104)**. On January 8, 2008 at 0350, you removed Tylenol (300 mg) with Codeine (30 mg) Elixir from the Pyxis **(Attachment 105)**. There was no physician order for this medication.

Patient #19 Ms. C.F.
Ms. C.F. was admitted to the EAU on January 6, 2008 with a diagnosis of Pneumonia. The physician ordered Tylenol 650 mg to be given every four hours as needed for mild pain **(Attachment 108)**. You removed the Tylenol from the Pyxis on January 6, 2008 at 2333 **(Attachment 109)**, but failed to document that it was administered on the patient's chart **(Attachment 110)**.

Patient #20 Mr. M.F.
Mr. M.F. was admitted to the EAU on January 4, 2008 with a diagnosis of alcohol withdrawal. The patient arrived on the unit at 0200 **(Attachment 111)** and had a physician order for Valium 10 mg to be given every hour until the patient was calm, but not sedated **(Attachment 112)**. You removed 10 mg from the Pyxis on January 4, 2008 at 0259 **(Attachment 113)**, but documented on the patient's chart that you administered the medication on January 4, 2008 at 2400 **(Attachment 114)**, which is two hours prior to the patient's arrival to the unit. There is no mention of distress or withdrawal symptoms in your nurse's notes **(Attachment 115)**.

Patient #21 Ms. E.R
Ms. E.R. was admitted to the EAU on January 2, 2008 with a diagnosis of new onset diabetes. The physician ordered Metformin 500 mg orally twice a day **(Attachment 116)**. You removed the medication from the Pyxis on January 3, 2008 at 0109 **(Attachment 117)**, but did not document that it was administered on the patient's chart **(Attachment 118)**. You instead documented that you gave the medication in your nurse's notes **(Attachment 119)**. You transferred the patient to another unit at 0445. It was the receiving nurse that indicated on the patient's chart that the medication was given in the EAU.

On January 2, 2008 at 2250, the physician ordered glucose monitoring to be obtained every four hours **(Attachment 120)**. You failed to document any of the blood glucose levels on the diabetic record during your shift for this patient **(Attachment 121)**.

Patient #22 Mr. V.B.
Mr. V.B. was admitted to the EAU on January 1, 2008 with a diagnosis of pneumonia. The physician ordered Heparin 5000 units subcutaneously every eight hours **(Attachment 122)**. You removed the medication from the Pyxis on January 3, 2008 at 0622 **(Attachment 123)**, but documented on the patient's chart that it was administered at 0500 **(Attachment 124)**.

The physician also ordered Percocet 1 to 2 tablets orally every four hours as needed for pain **(Attachment 125)**. You administered two doses. You removed the second dose from the Pyxis on January 3, 2008 at 0620 **(Attachment 123)**, but documented on the patient's chart that you administered the medication at 0700 **(Attachment 126)**. You failed to document the severity of the pain in your nurse's notes **(Attachments 127 and 128)**.

Investigational Interview

An investigational interview was held on April 14, 2008 at 1230. Present were you, your RNPA representatives, Liz La Rosa and Jane Valdez, Suzie Minnich, Nurse Manager MICU/CCU and Ms. Kelton. They reviewed the identified nursing performance issues.

Patient #1 (Ms. E.M.)
You acknowledged that the patient was alert and that you remembered the family being with the patient all night. You stated that you did administer the two doses of Heparin and two doses of Metoprolol that were ordered. You told Ms. Kelton that you had not removed the medications from the Pyxis but instead had retrieved the medications from the medication cart. You said that the unit had been stocking Heparin in the medication cart since Grace was the Assistant Nurse Manager and that the Metoprolol had been delivered to the unit by the pharmacy.

You discussed the physician order, which was to hold the Metoprolol for a systolic blood pressure less than 100 and a heart rate less than 60. Ms. Kelton showed you the 2400 vital signs and asked why there were no vital signs documented at 0400. You stated that the HSA (nursing assistant) must have forgotten to write them down, but did obtain them and that is how you knew that it was okay to administer the second dose of Metoprolol at 0600. You also stated that you relied on the EKG for the heart rate. Ms. Kelton pointed out that the EKG could not obtain the blood pressure and you agreed. You acknowledged that it was your responsibility to ensure that the vital signs were obtained and documented every four hours as ordered.

Patient #2 (Ms. T.O.)
You acknowledged that you had not documented the Tylenol on the patient's chart nor did you indicate that the patient had pain or fever. Ms. Kelton reminded you that when medications are removed from the Pyxis, they are automatically charged as a cost to the patient. If there is no documentation that a medication is given, insurance companies view this as a false patient charge. She also told you that if you do not document when medications are given, then the next nurse may give the next dose of the medication either too soon or too late.

Patient #3 (Ms. L.S.)
You stated that you did not give the 0600 dose of Hydrocortisone because it had been discontinued. Ms. Kelton asked why 0600 was written on the medication record. You said that

your habit is to first write down all the times on the medication record when the medication will be due. Then, when you go to administer the medications, you initial below the time. You showed me that the 0600 entry did not have your initials below the written 0600 and that is how you knew that you did not give that dose of medication. She told you that this was an unsafe practice. She told you that the entry of time is to be written after the medication is administered.

You said that you did remember giving the Morphine after the patient came back from the ultrasound, which according to your nurse's notes was at 2200. You acknowledged that the time you documented on the medication record was not accurate. Again, she informed you that if the time is wrong, then the next dose might be given too soon. You said that you thought that medications could be given either one hour before or one hour after the schedule administration time. She told you that our policy is that medication can be given either thirty minutes before or thirty minutes after the scheduled time and documentation is to reflect the actual time that medications are administered.

They discussed the two doses of Azithromycin that you documented as given on March 29, 2008 at 0030. You told Ms. Kelton that the 500 mg dose was given in the Emergency Department. She asked why you documented that you gave it on the medication record and showed you that the order was written in the EAU, not the Emergency Department. When asked why you gave two doses, you stated that you thought the physician wanted both doses given. She reviewed the Nursing 2007 drug handbook with you, which did not state that 750 mg was a standard dose. She asked why you did not call the physician to clarify the order. You did not reply.

You stated that you removed the Nitroglycerin for the patient just in case the patient had chest pain, but she did not. Ms. Kelton asked if you returned the medication and you responded that you did not think so. She told you that the patient was charged for the bottle of medication.

Patient #4 (Ms. I.S.)
You verified that you did administer the Ativan because the patient was anxious and crying. They discussed the accuracy of your times for administration and the fact that there was no documented response to the medication, as is required for all medications that are administered on an as needed basis.

They discussed the Morphine, which was removed from the Pyxis on April 1, 2008 at 0136. You said that you did waste the 1 mg of Morphine. Ms. Kelton showed you the Pyxis report that indicated that the additional medication had not been wasted and that there was no response to the medication in your nurse's notes. You verified this data.

Patient #5 (Ms. C.O)
You claimed that the patient was drug seeking. They reviewed the Pyxis report, which indicated the Morphine was removed from the Pyxis on March 16, 2008 at 0049. They then viewed the medication record, which showed that you documented that the dose was given at 0300. During the interview, you stated that the time was actually 0200. Ms. Kelton asked, since you did not initial under the time, did you really give the medication since you told me earlier that if there was no initial, it was not given. You indicated that you thought you had administered the dose. Ms. Kelton told you that she was concerned about the amount of time between removing

narcotics from Pyxis to administration to the patient. Our policy requires narcotics to be locked up. Narcotic drawers have a double lock and the Pyxis machine is secured. You said that you must have gotten "side tracked".

Ms. Kelton told you that the physician ordered the Morphine only for severe pain rated 8/10 and above on the pain scale. Your documentation was 6/10 for one of the doses and no mention of pain for the other two. You stated that the patient did not like Vicodin and that is why you gave the Morphine. You did acknowledge that your times "were off."

Patient #6 (Mr. E.O.)
You wondered how you could have documented that you gave the Morphine at 0100 when the patient did not arrive on the unit until 0330. Ms. Kelton told you that she was concerned about your time and that the extra 1 mg of this medication had not been wasted. The pain was also less than what was required for administration. You rated it as 6/10 but the physician's order stated 8/10 or greater. Ms. Kelton said that she was concerned because the second dose of Morphine was given only two hours and twenty minutes after the previous dose. The physician's order was for every four hours as needed. You thought that the Pyxis machine time might not be correct. Ms. Kelton informed you that she had verified the accuracy of the time on the machine with the pharmacist. You then said that you thought it was a one-time order and she showed you the order, which verified that it was not.

They discussed the Heparin. Ms. Kelton asked why you documented that you gave the medication at 0500 when it was removed from the Pyxis at 0604. You said that you gave it at 0600. Ms. Kelton showed you the time on the medication record, which clearly reflected 0500.

They then discussed the Thiamine. Ms. Kelton showed you the documents showing you removed the medication on March 16, 2008 at 0606, but charted on the patient's chart that it was given on March 15, 2008 at 2300, which was four hours and thirty minutes before the patient arrived on the unit. You said that the time of admission must be a mistake. Ms. Kelton showed you the documented admission time that you had entered on both the first page of the Hospital Admission Assessment and your narrative note on the last page of this document. You asked if the over ride function was used and Ms. Kelton showed you the report, which revealed that it was not.

Patient #7 (Mr. RD)
Ms. Kelton informed you that the Tylenol was removed from the Pyxis but not documented on the patient's chart and there was no mention of pain. You stated that the patient was to go for a cardiac cath.

Patient #8 (Mr. MR)
You informed Ms. Kelton that the patient removed his IV, it was difficult to insert the IV for the patient and that is why the Dilaudid was removed at 2019, but not administered until 2200. When asked what you did with the narcotic, you said you put it in your pocket and got "side swiped". Ms. Kelton again stated that narcotics need to be secured and that you should have returned it to the Pyxis. You also acknowledged that pain was not documented in your nurse's notes.

You stated that you did give the Trazadone, but did not document it on the patient's chart. Ms. Kelton showed you the nurse's notes, which did not mention insomnia.

At this point in the investigation your RNPA representative, Jane Valdez, felt they had seen enough documentation. Ms. Kelton did summarize the list of medications given without a physician's order, medications documented as administered on the patient's chart but not removed from Pyxis; medications removed from the Pyxis but not documented on the patient's chart and the charting variances such as medications given too soon / given too late; lack of co-signature on Insulin, blood sugar levels not obtained; lack of pain assessment and response to pain medications. You told Ms. Kelton, "Sometimes the doctor says to give something and will write for it later."

Because of all the narcotic discrepancies, Ms. Kelton told you that it made her suspect diversion of drugs. You replied, "I'm pretty sure that I didn't use it".

You told Ms. Kelton that sometimes you remove medications for other nurses. Ms. Kelton told you that she pulled the report for each patient, not just your individual activity so that she was sure that someone else did not give medications for your patients. They did not. You acknowledged that there was no excuse for what was found. Ms. Kelton told you that you were not following basic nursing practice.

Because of the probationary status with the Board of Registered Nurses, Ms. Kelton asked if you had notified your probation monitor of your administrative leave status and you replied that you had left a message with your probation monitor. Your RNPA representative asked about the conditions of your probation and the restrictions for employment, which Ms. Kelton explained. Ms. Kelton told you that she had notified the Board of Registered Nurses of her concerns on April 3, 2008.

Ms. Kelton said that although she had agreed to provide supervision to the level your probationary status required, based on these gross errors in your nursing practice, even that was clearly not enough to ensure patient safety. Ms. Kelton told you that these recent events were all errors in "basic nursing practice".

Ms. Kelton provided you with the phone number and address for the Employee Assistance Program. She explained the program and the benefits available to you as a County employee. You agreed to call them.

Past Discipline / Coaching

- 3/17/08 Coaching - Complaint from 4 Med RN, which includes incomplete inter-shift report. Orders not transcribed or implemented. Morning lab draws not obtained. Complaint from 3 Surgical RN, which includes patient complaint that medications and respiratory treatment were not given. Blood glucose not obtained. Unprofessional attitude. PPD not administered. 2 sets of blood cultures not drawn. Wrong diet reported to oncoming RN. Medications not given. You denied these allegations **(Attachment 129)**.

- 5/11/07 Coaching – Reminded of BRN restrictions regarding working no more than 80 hours per pay period and no overtime (reported infraction to the BRN on 5/3/07)

- 9/8/06 – Written counseling for excessive unscheduled absences **(Attachment 130)**.

Summary

As a Clinical Nurse III, you are expected to possess the knowledge, experience and professional judgment required to identify and implement nursing interventions. You are also expected to evaluate the results of the interventions. You have failed to meet this standard, and as a result, have jeopardized the safety of your patients. You have:

- Administered medications without a physician order;
- Created multiple patient charges for medications that were removed from the Pyxis, but not documented as given to the patient;
- Failed to administer medications and implement the plan of care;
- Failed to observe the five rights of medication administration: the right patient, the right medication, the right dose, the right route and the right time;
- Failed to document location and severity of pain prior to giving pain medication;
- Failed to document the response to pain medication;
- Failed to document vital signs and blood glucose levels;
- Failed to document in a clear, concise, accurate and legible manner, which impacts continuity of care;
- Failed to administer scheduled medications within the window of thirty minutes before or after the time of the scheduled dose;
- Failed to keep narcotics in a lockable secured area;
- Failed to have the Insulin checked by two licensed nurses;
- Failed to indicate the reason why medications were not given on the medication record;
- Failed to perform wastage of narcotics when the entire dose is not administered to the patient;
- Failed to document the administration of medication immediately "after" it is given on the medication record.

When medications are not documented as given on the medication record, many problems can occur. An extra dose may be given, which can result in over dosing or a delay in the course of treatment. If a medication is prescribed and not given, symptoms may worsen.

There must be documentation that supports the need to administer medications that are given on an as needed basis. When pain medications are given both the location and severity of pain must also be assessed and documented. When you fail to assess pain location and severity, you cannot justify the need for administering the medication. When you do not assess and document the response to the medication, you cannot determine if it was effective.

Physicians routinely look at the medication record to assess the status of the patient. If they find that the patient has not required pain medication such as Tylenol, Vicodin or Morphine the

physician may assume that the status of the patient has improved. Or a physician may have assumed that a patient's nausea and vomiting had resolved. In each of these examples, the physician may change the dose of the medication or discontinue it because they believe the symptoms have improved without the need of medication, which may ultimately, result in misinterpretation and/or worsening of symptoms.

When medications are removed from the Pyxis, but not documented on the medication record, the patient will be charged for the medication even though the medication was not given. This is a compliance issue, which places the hospital at risk for falsifying patient charges.

The time that medications are administered must be accurately recorded on the medication record. When medication administration times are not accurate, a dose of medication may be given too early (over dosing) or too late (under dosing). On numerous occasions, the time that you removed medications from the Pyxis did not correspond with the time that you documented that the medications were given. Per policy, medication can be administered up to 30 minutes before or after the time of the scheduled dose. Medication must also be stored in a secured / locked area.

Any wastage of a controlled substance must be witnessed and co-signed by another licensed staff member in the Pyxis.

Giving medications without a physician's order is not within your scope of practice and is dangerous. Considerations such as allergy to medication and drug to drug interactions must be assessed by the physician. Some drugs are incompatible with others and the screening process must be performed to assess this risk.

Conclusion

On multiple occasions, you have jeopardized the safety of your patients and placed Santa Clara Valley Medical Center at risk for liability. Patients admitted to the hospital are vulnerable and expect to be safe in their environment. They place their trust in the nursing staff, whose role is to be the patient advocate. Your practice has both jeopardized the safety of our patients and hindered the treatment plan prescribed by the physician. You have violated the California Nurse Practice Act and have not demonstrated competent performance. As a registered nurse, you are required to implement the treatment plan, observe signs and symptoms of illness and reactions to treatment. You are to recognize whether these signs and symptoms are normal or abnormal. You have failed to do so. You have failed to demonstrate the nursing process in a responsible, accountable, and ethical manner. Ms. Kelton has supervised your Board of Registered Nurses probationary status in the manner required, however we cannot supervise every aspect of your nursing care. As required, Ms. Kelton has notified the Board of Registered Nurses that she is unable to provide the supervision that is required to ensure that your practice is safe and is hereby recommending that you be terminated from your position as Clinical Nurse III in the EAU effective August 21, 2008.

Hearing

A hearing was scheduled for July 31, 2008. I was contacted by RNPA prior to that date, stating that you had chosen to forgo the hearing.

Hearing Officer's Decision

After reviewing the charging letter and documentary evidence, I have decided to **sustain** the disciplinary action. Therefore, you will be terminated from your position as a Clinical Nurse III in the EAU (Express Admission Unit) at Santa Clara Valley Health and Hospital System (SCVHHS) effective **August 21, 2008**.

Right of Appeal

Should you be dissatisfied with the final action, you have appeal rights under County of Santa Clara Charter, section 708(c):

> "The employee shall have ten working days from receipt of such written notice within which to file an answer to the statement of charges should the employee desire to do so, and the filing of such an answer shall be deemed to be an automatic request for a hearing unless such employee otherwise indicates. The answer to such charges shall be filed wit the Personnel Board."

Alternatively, should you voluntarily waive your right to appeal this disciplinary action to the Personnel Board, you may exercise your rights in accordance with Section16.1 (b) of the Grievance Procedure of the Memorandum of Understanding between the County and RNPA.

You have the right to be represented in your appeal by your union RNPA or other representative of your choice.

You have a right to written materials on which the recommended discipline is based. For your convenience, the materials have been attached to this document.

Sincerely,

Cheryl Dewey

Cheryl Dewey, RN
Hearing Officer
Nurse Manager, Pediatrics/Pediatric ICU

Att.:

1. Merit System Rules
2. SCVMC Nursing Service Standards of Governance, QI-31
3. SCVMC Nursing Service Standards of Care, DOC-4
4. SCVMC Nursing Service Standards of Care, MED-1

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MERCEDES APOSTOL TATEL 1307 Tofts Drive San Jose, CA 95131 Registered Nurse License No. 470862 Respondent	Case No. 2006-233

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as it's Decision in the above entitled matter.

This Decision shall become effective on January 22, 2007.

IT IS SO ORDERED December 22, 2006.

Louise W. Tate

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

BILL LOCKYER, Attorney General
of the State of California
FRANK H. PACOE
Supervising Deputy Attorney General
LESLIE E. BRAST, State Bar No. 203296
Deputy Attorney General
California Department of Justice
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5548
Facsimile: (415) 703-5480

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MERCEDES TATEL** 1307 Tofts Drive San Jose, CA 95131 Registered Nurse License No. 470862 Respondent.	Case No. 2006-233 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Board of Registered Nursing of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) is the Executive Officer of the Board of Registered Nursing. She brought this action solely in her official capacity and is represented in this matter by Leslie E. Brast, Deputy Attorney General, for Bill Lockyer, Attorney General of the State of California.

2. Respondent Mercedes Tatel (Respondent) is represented in this proceeding by attorney Alicia Queen, whose address is 1440 Broadway, Suite 814, Oakland, CA 94612.

3. On or about August 31, 1991, the Board of Registered Nursing issued to Respondent Registered Nurse License No. 470862. The License was in full force and effect at all times relevant to the charges brought in Accusation No. 2006-233 and will expire on June 30, 2007, unless renewed.

JURISDICTION

4. Accusation No. 2006-233 was filed before the Board of Registered Nursing (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 31, 2006. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 2006-233 is attached as **exhibit A** and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 2006-233. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

//

//

//

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 2006-233.

9. Respondent agrees that her Registered Nurse License is subject to discipline and she agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CIRCUMSTANCES IN MITIGATION

10. Respondent has never been the subject of any disciplinary action. She is admitting responsibility at an early stage in the proceedings and has been cooperative throughout. Respondent has been continuously employed since the incident which gave rise to the pending Accusation. She submitted a packet of mitigation evidence including a positive performance evaluation from Good Samaritan Hospital from the period between December 2004 and December 2005 and several letters of recommendation. These include a letter dated September 19, 2006, from Nicole Vecchi, MD, with whom Respondent has worked for almost two years. It describes Respondent as "an excellent nurse, very knowledgeable." Also included is a letter from P. Cook, BSN, Director of Surgical Services at Good Samaritan, which describes Respondent as highly skilled, hard working, resourceful, flexible and well respected.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board of Registered Nursing. Respondent understands and agrees that counsel for Complainant and the staff of the Board of Registered Nursing may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect and, except for this paragraph, it shall be inadmissible in any

legal action between the parties. The Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

//

//

//

//

//

//

//

//

//

//

//

//

//

//

//

//

//

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Registered Nurse License No. 470862 issued to Respondent Mercedes Tatel is revoked; however, the revocation is stayed and Respondent is placed on probation for three (3) years subject to the following terms and conditions.

Severability Clause. Each condition of probation contained herein is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

1. **Obey All Laws.** Respondent shall obey all federal, state and local laws. A full and detailed account of any and all violations of law shall be reported by Respondent to the Board in writing within 72 hours of occurrence. To permit monitoring of compliance with this condition, Respondent shall submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision, unless previously submitted as part of the licensure application process.

2. **Comply with the Board's Probation Program.** Respondent shall fully comply with the conditions of the Probation Program established by the Board and cooperate with representatives of the Board in its monitoring and investigation of the Respondent's compliance with the Board's Probation Program. Respondent shall inform the Board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license status with the Board, including during any period of suspension.

Upon successful completion of probation, Respondent's license shall be fully restored.

3. **Report in Person.** Respondent, during the period of probation, shall appear in person at interviews/meetings as directed by the Board or its designated representatives.

4. **Residency, Practice, or Licensure Outside of State.** Periods of residency or practice as a registered nurse outside of California shall not apply toward a reduction of this probation time period. Respondent's probation is tolled, if and when she resides outside of

California. Respondent must provide written notice to the Board within 15 days of any change of residency or practice outside the state, and within 30 days prior to re-establishing residency or returning to practice in this state.

Respondent shall provide a list of all states and territories where she has ever been licensed as a registered nurse, vocational nurse, or practical nurse. Respondent shall further provide information regarding the status of each license and any changes in such license status during the term of probation. Respondent shall inform the Board if she applies for or obtains a new nursing license during the term of probation.

5. **Submit Written Reports.** Respondent, during the period of probation, shall submit or cause to be submitted such written reports/declarations and verification of actions under penalty of perjury, as required by the Board. These reports/declarations shall contain statements relative to Respondent's compliance with all the conditions of the Board's Probation Program. Respondent shall immediately execute all release of information forms as may be required by the Board or its representatives.

Respondent shall provide a copy of this Decision to the nursing regulatory agency in every state and territory in which she has a registered nurse license.

6. **Function as a Registered Nurse.** Respondent, during the period of probation, shall engage in the practice of registered nursing in California for a minimum of 24 hours per week for six consecutive months or as determined by the Board.

For purposes of compliance with the section, "engage in the practice of registered nursing" may include, when approved by the Board, volunteer work as a registered nurse, or work in any non-direct patient care position that requires licensure as a registered nurse.

The Board may require that advanced practice nurses engage in advanced practice nursing for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

If Respondent has not complied with this condition during the probationary term, and Respondent has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may

grant an extension of Respondent's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation shall apply.

7. **Employment Approval and Reporting Requirements.** Respondent shall obtain prior approval from the Board before commencing or continuing any employment, paid or voluntary, as a registered nurse. Respondent shall cause to be submitted to the Board all performance evaluations and other employment related reports as a registered nurse upon request of the Board.

Respondent shall provide a copy of this Decision to her employer and immediate supervisors prior to commencement of any nursing or other health care related employment.

In addition to the above, Respondent shall notify the Board in writing 72 hours after she obtains any nursing or other health care related employment. Respondent shall notify the Board in writing within 72 hours after she is terminated or separated, regardless of cause, from any nursing or other health care related employment with a full explanation of the circumstances surrounding the termination or separation.

8. **Supervision.** Respondent shall obtain prior approval from the Board regarding Respondent's level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse or education and training that includes patient care.

Respondent shall practice only under the direct supervision of a registered nurse in good standing (no current discipline) with the Board of Registered Nursing, unless alternative methods of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are approved.

Respondent's level of supervision and/or collaboration may include, but is not limited to the following:

(a) Maximum - The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

(b) Moderate - The individual providing supervision and/or collaboration is in

the patient care unit or in any other work setting at least half the hours Respondent works.

(c) Minimum - The individual providing supervision and/or collaboration has person-to-person communication with Respondent at least twice during each shift worked.

(d) Home Health Care - If Respondent is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with Respondent as required by the Board each work day. Respondent shall maintain telephone or other telecommunication contact with the individual providing supervision and/or collaboration as required by the Board during each work day. The individual providing supervision and/or collaboration shall conduct, as required by the Board, periodic, on-site visits to patients' homes visited by Respondent with or without Respondent present.

9. **Employment Limitations.** Respondent shall not work for a nurse's registry, in any private duty position as a registered nurse, a temporary nurse placement agency, a traveling nurse, or for an in-house nursing pool.

Respondent shall not work for a licensed home health agency as a visiting nurse unless the registered nursing supervision and other protections for home visits have been approved by the Board. Respondent shall not work in any other registered nursing occupation where home visits are required.

Respondent shall not work in any health care setting as a supervisor of registered nurses. The Board may additionally restrict Respondent from supervising licensed vocational nurses and/or unlicensed assistive personnel on a case-by-case basis.

Respondent shall not work as a faculty member in an approved school of nursing or as an instructor in a Board approved continuing education program.

Respondent shall work only on a regularly assigned, identified and predetermined worksite(s) and shall not work in a float capacity.

If Respondent is working or intends to work in excess of 40 hours per week, the Board may request documentation to determine whether there should be restrictions on the hours of work.

10. **Complete a Nursing Course(s).** Respondent, at her own expense, shall

enroll and successfully complete a course(s) relevant to the practice of registered nursing no later than six months prior to the end of her probationary term.

Respondent shall obtain prior approval from the Board before enrolling in the course(s). Respondent shall submit to the Board the original transcripts or certificates of completion for the above required course(s). The Board shall return the original documents to Respondent after photocopying them for its records.

11. **Cost Recovery.** Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $5.000.00. Respondent shall be permitted to pay these costs in a payment plan approved by the Board, with payments to be completed no later than three months prior to the end of the probation term.

If Respondent has not complied with this condition during the probationary term, and Respondent has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of Respondent's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation will apply.

12. **Violation of Probation.** If Respondent violates the conditions of her probation, the Board after giving Respondent notice and an opportunity to be heard, may set aside the stay order and impose the stayed discipline (revocation/suspension) of Respondent's license.

If during the period of probation, an accusation or petition to revoke probation has been filed against Respondent's license or the Attorney General's Office has been requested to prepare an accusation or petition to revoke probation against Respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been acted upon by the Board.

13. **License Surrender.** During Respondent's term of probation, if she ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the conditions of probation, Respondent may surrender her license to the Board. The Board reserves the right to

evaluate Respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances, without further hearing. Upon formal acceptance of the tendered license and wall certificate, Respondent will no longer be subject to the conditions of probation.

Surrender of Respondent's license shall be considered a disciplinary action and shall become a part of Respondent's license history with the Board. A registered nurse whose license has been surrendered may petition the Board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision:

(1) Two years for reinstatement of a license that was surrendered for any reason other than a mental or physical illness; or

(2) One year for a license surrendered for a mental or physical illness.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Alicia Queen. I understand the stipulation and the effect it will have on my Registered Nurse License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

DATED: 10/17/06

Mercedes A. Tatel

MERCEDES TATEL
Respondent

//

//

//

//

//

I have read and fully discussed with my client, Mercedes Tatel, the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 10/17/06.

ALICIA QUEEN
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Board of Registered Nursing of the Department of Consumer Affairs.

DATED: Oct 18, 2006

BILL LOCKYER, Attorney General
of the State of California

FRANK H. PACOE
Supervising Deputy Attorney General

LESLIE E. BRAST
Deputy Attorney General

Attorneys for Complainant

DOJ Matter ID: SF2006400144
40111503.wpd

Exhibit A

Accusation No.

BILL LOCKYER, Attorney General
of the State of California
LESLIE E. BRAST, State Bar No. 203296
Deputy Attorney General
California Department of Justice
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5548
Facsimile: (415) 703-5480

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MERCEDES APOSTOL TATEL** 1307 Tofts Drive San Jose, CA 95131 Registered Nurse License No. 470862 Respondent.	Case No. 2006-233 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1991, the Board of Registered Nursing issued Registered Nurse License Number 470862 to Mercedes Apostol Tatel (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2007, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

STATUTORY PROVISIONS

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

6. Code section 2725, subdivision (b)(1) states, in pertinent part, that the practice of nursing requires a substantial amount of scientific knowledge and includes "performance of disease prevention."

7. Code section 2761 states, in pertinent part: "The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . .

(k) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of blood-borne infectious diseases from licensed or certified nurse to patient, from patient to patient, and from patient to licensed or certified nurse."

8. California Code of Regulations, title 16, section 1442, states:

> "As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL BACKGROUND

10. Between January 2003 and August 2004, Respondent was Director of Nursing (DON) at Los Gatos Oaks Convalescent Hospital in Santa Clara County and the facility's infection control nurse. Respondent's husband, E.T.[1], joined the staff on April 1, 2003, as a licensed vocational nurse (LVN) under her supervision. Despite a documented history of a previous positive tuberculosis skin test (TST), and despite stipulated county guidelines, E.T. was not required to have a chest x-ray before his April 2003 hire.

11. A facility physician saw E.T. on August 18, 2004, for hemoptysis (bloody sputum) and weight loss and ordered a chest x-ray[2]. On August 20, 2004, the physician notified Respondent that the results of the x-ray suggested suspected active tuberculosis (TB). Respondent nevertheless allowed E.T. to work one shift on August 23, 2004, potentially exposing patients, visitors, staff, and their families to a highly communicable infectious disease.

12. Despite her knowledge that a staff member had suspected active TB, Respondent failed to report it to county and state public health authorities within one working day of identification pursuant to Santa Clara County TB guidelines and title 17 of the California Code of Regulations. Instead, she waited four days before notifying county authorities on August 24, 2004, and five days before notifying the state Department of Health Services (DHS) on August 25, 2004.

---

1. Initials are substituted for E.T.'s name which has been redacted in order to protect his privacy.

2. E.T. reportedly had a negative chest x-ray for TB on September 8, 2000, but in January 2003 was subsequently examined by the same facility physician for hemoptysis. E.T. was also seen by the physician on March 26, 2004 and again on July 14, 2004 when the physician ordered an x-ray. It appears that E.T. did not follow through until another x-ray was ordered August 18, 2004.

13. Respondent likewise failed to report a newly admitted resident's August 16, 2004, chest x-ray which was suspicious for TB following a positive TST August 15, 2004. The facility policy regarding airborne precautions for residents suspected of TB was not followed until August 31, 2004. Other failures include improper documentation following positive TSTs on two of twenty-seven residents who both converted from negative to positive TB status between May 7, 2004, and August 27, 2004[3].

14. Respondent failed to provide employee training in the care of residents with TB as required by facility policy.

15. Respondent was responsible for administering the facility's infection control program but failed to collect data, determine and track rates of infection or outbreak of infectious disease, make infection control findings, recommendations and establish corrective actions. A DHS investigation revealed that the facility had, in effect, no functioning infection control program between August 2003 and August 2004.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence: Exposure to Infectious Disease)

16. Respondent is subject to disciplinary action under Code section 2761, subdivision (a) for gross negligence in that, as DON and infection control nurse for a convalescent hospital, she:

a. Failed to exercise ordinary caution when she allowed a staff member with suspected active TB to work a shift at the facility, knowingly exposing residents, visitors, staff and their families to a significant risk of transmission of infectious disease which she knew, or should have known, could have jeopardized their health or lives; and

b. Failed to exercise ordinary caution in her repeated failure to identify, prevent, control and report TB during the course of a year-long period.

17. The circumstances are detailed in paragraphs 10–15 above.

---

3. Additionally, thirty facility employees were tested for TB exposure but the results of employee testing were not included in DHS documents.

SECOND CAUSE FOR DISCIPLINE

(Failure to Perform Disease Prevention)

18. Respondent is subject to disciplinary action under Code section 2725, subdivision (b)(1) in that, as DON and infection control nurse at a convalescent hospital, she failed to perform disease prevention in her repeated failures to identify, prevent, control and report TB. The circumstances are described in paragraphs 10–15 above.

THIRD CAUSE FOR DISCIPLINE

(Failure to Follow Infection Control Guidelines)

19. Respondent is subject to disciplinary action under Code section 2761, subdivision (k) in that, as DON and infection control nurse at a convalescent hospital, she knowingly failed to protect patients and staff from risk of transmission of blood-borne infectious disease by repeatedly failing to identify, prevent, control and report TB as required by facility policy, county TB guidelines and state regulations for infection control. The circumstances are detailed in paragraphs 10–15 above.

//

//

//

//

//

//

//

//

//

//

//

//

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 470862, issued to Mercedes Apostol Tatel;

2. Ordering Mercedes Apostol Tatel to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 5/22/06

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2006400144
lb031706